The response to various activities undertaken by the mobile teams is generally very positive. The communities respond not only by accepting the presence of the mobile teams but by participating enthusiastically in:

(i) Electing a Health Committee made up of recognised leaders of each tribal group;

(ii) Nominating men as candidates for the position of CHS who conform to the criteria of selection. The CHS will become a paid employee of the BHU and responsible to the Government of Pakistan;

(iii) Electing a voluntary worker, i.e. a CHW, on the basis of one per thirty families.

The importance of the interest taken by the BHU Medical Officers and the support of the refugee village administration personnel should not be overlooked. In a few areas where these two aspects were rather below the desired levels, the progress of the programme was considerably retarded.

5.1.2. Formation of the Health Committee

Assisted by the mobile teams, a Health Committee is formed by the community for the area served by each BHU.

It is made up of respected representatives of the various factions of the community, representatives of the BHU, (ie Medical Officers), and of the refugee village administration, in order to ensure that everyone concerned with the provision of services and facilities in the refugee village assists with the development of the community orientated health programme.

The idea behind the formation of the Health Committee is that, since it is not possible to consult large numbers of people about different activities or problems, their recognised leadership is used for the purpose and is expected to perform the following roles;

(i) To present the views of the community on the health problems in the refugee village:

(ii) To decide which health problems can be solved through community efforts such as improving the water supply, drainage and sanitation systems;

(iii) To motivate the community to work together to solve problems;

(iv) To inform the community about health problems and related activities and to help solve any difficulties that exist in carrying them out;

(v) To encourage the active participation of the community in the programme;

(vi) To put forward suitable candidates acceptable to the community for the selection of CHSs;

(vii) To motivate members of the community to train as volunteer CHWs;

(viii) To support the CHWs in their work;

(ix) To liaise with the BHU and refugee village administration.

5.1.3. Selection and Training of Community Health Supervisors

After the phase of motivation and explanation of the programme, the community demonstrates its involvement by nominating candidates for the post of CHS.

Although as many as 10-12 people can be nominated, only one per 7,500 population is finally selected after a test and an interview.

Nomination and selection are based on strict criteria, which ensure that the candidates must:

(i) be nominated by the community;

(ii) be acceptable to the community;

(iii) be able to move freely thoughout the refugee village;

(iv) be literate;

(vi) be 25 years of age or over;

(v) be a registered refugee;

(vii) be a resident of the same refugee village;

(viii) have a good personality and even disposition and be well respected by all factions of the community;

(ix) have a sound religious knowledge;

(x) undertake the test and interview successfully.

The test and interview are designed to gauge the candidate's perceptions, attitudes, understanding and ability to communicate with regard to health care and teaching.

Approximately two hours are allowed for the test. The papers are coded so that the candidates remain anonymous to the markers of the papers. After the papers are marked, an interview is held for all the candidates in collaboration with the FSMO, who is the head of the health sector in his district. The Medical Officer and the Refugee Village Administrator are also invited. They attend the interview only to give an opinion and are not involved in the process of selection, since they deal daily with the candidates and might be exposed to accusations of bias or favouritism. The scores for the test and interview performance are then assessed. The most appropriate candidate is chosen for training and his name is announced to the community through a Jirga (a traditional meeting with quasi-judicial functions).

Having been selected, the CHSs undergo 10-12 weeks of training at the SCF Badaber Training Centre near Peshawar. The course is designed to train the CHS in the PHC curriculum and how to communicate their knowledge, the emphasis being on the practical application of theory. The CHSs are given enough time for teaching practice and practical preparation of lessons.

The CHSs are continuously assessed during this phase, at the end of which they take a written and practical test. The areas in which they are weak are revised.

After completion of this course, the CHSs return to their camps to undergo four weeks of intensive training, supervised by SCF teachers. During this time they train the CHWs. During this phase the CHSs are also taught to play their roles as part of the BHU staff. On successfully completing the training of CHWs, the CHSs qualify and become paid employees of the Basic Health Unit.

5.1.4. Selection and Training of Community Health Workers

Motivated by the mobile teams, the Health Committees and the CHSs, the community nominates one CHW for every thirty families.

It is recommended that a CHW should:

(i) be resident in the camp at all times;

(ii) be a respected and stable member of the community, able to visit the homes and have access to the women of his thirty family cluster;

(iii) be over 18; younger men may train as CHW's but they are not eligible to receive kits;

(iv) be prepared to volunteer his services.

CHWs are always male and not necessarily literate. They work on a voluntary basis and their training is planned so as to take account of their work commitments.

The training of a CHW lasts for approximately 8-12 weeks and is conducted in a refugee village for two hours per day. The duration of training is flexible and depends on the time that the CHSs and the PHC teachers of SCF have been able to give for teaching CHWs, as well as the speed with which the CHWs understand the subjects taught.

5.1.5. Training Curricula for CHS/CHWs

The training of the CHSs and CHWs is aimed at making them good teachers, able to communicate simple health messages, to act as a link between the BHU and the community, and as an extension of the services provided by the BHU.

The curriculum was developed after a careful study of the disease patterns in the Afghan refugee villages, the aims and objectives of the programme, the cultural patterns of the Afghan refugees and existing preventive health programmes in Pakistan, Afghanistan and other countries. The syllabus covers the recognition, early treatment and prevention of the main diseases, and most of the basic communicable diseases seen in Afghan refugee villages, as well as criteria for referral to the BHU.

Teaching methods have been carefully developed to train both CHSs and CHWs as teachers in the first hand management and prevention of disease.

The training gives a brief account of diseases, paths of infection and the causal chain of diseases that combine and result in illness, before teaching about the management and prevention of disease.

This ensures that CHSs and CHWs learn to teach in a way which is culturally acceptable to the community. CHSs and CHWs are also taught about their job descriptions, and the reporting and referral systems.

5.2. Phase 2: Management

Having laid down a strong foundation in the initial preparatory phase, i.e. having motivated the community and health staff, and having trained the CHSs and CHWs, the programme is handed over for management and supervision to the health authorities of the ARO.

From this point on SCF's role becomes that of a technical advisor. But SCF's services remain invaluable in providing guidance and keeping up the training standards of CHSs and CHWs through regular assessment and refresher courses, and by providing the necessary feedback.

Although the management of the two phases is different - the initial preparatory phase being handled by SCF and the second dealt with by the health sector of the ARO - the importance of the correct balance between the two cannot be over emphasised.

However, before discussing the management of the programme it would be appropriate to discuss a few issues that have implications for PHC programmes in general and for Afghan refugees in particular.

5.3. Factors for Successful Implementation of PHC

In discussing the factors required for the successful implementation of a PHC programme the situation must be viewed from the very start of the training of the different personnel. Their working conditions, job security and satisfaction all have to be kept in mind. These factors are, in order of importance:

5.3.1. Role of Government

In line with its decision to reach the masses and to raise the overall health standards of communities, the Government must make a firm commitment to the implementation of PHC. In doing so the following will have to be taken into account:

a) *Resource allocation and provision of appropriate technology;*

The heading is self-explanatory and is related to all the factors that follow.

b) *Change in training system;*

(i) Medical training:

Much more emphasis and importance must be given to the training of medical students in preventive medicine and public health. This training should cover not just theory but PHC management, taught through theoretical modules as well as practical attachments. Practical attachments have a similar function to attachments for medical students on different aspects of curative medicine.

Needless to say health education, management and community participation should be included as priorities in the training curriculum.

(ii) Training of paramedics and other staff:

These categories of staff at the BHU, in general, are more inclined towards a passive approach than to the all important outreach activities. What is needed is a change in the way they are trained. This could be achieved by arranging attachments to operational PHC programmes during training, emphasising the importance of outreach activities, health education and community participation in practical situations, and emphasising these areas in theoretical curricula.

(iii) CHS/CHW training and community involvement:

The importance of training for these categories of staff cannot be over emphasised. This has been adequately dealt with in discussing Phase 1 of the programme. All that needs to be said here is that the training curricula and methods developed by SCF(UK) for the CHSs and CHWs in the Afghan refugee organisation and their methods for involving the community have proved to be extremely appropriate.

(iv) In-service training:

In-service training and refresher courses should be held for all staff categories from time to time to keep them interested and up to date about their fields.

(v) Multi-sectoral approach:

It is said that war is too important for soldiers to fight about. Similarly, health is too important to be left to health service personnel alone.

The impact and success of PHC is dependent on several different sectors, such as the medical sector, the community and the various departments engaged in development work, the rule of law, etc.

The collaboration and cooperation of all these sectors is there fore a prerequisite for success. While it is true that a reasonable degree of cooperation can sometimes be achieved by the PHC authorities, this is not always possible. In such cases it is up to Government to take a policy decision giving the PHC authorities a strong say in the coordination of different preventive health programmes from field level through the tiers of administration up to ministerial departments.

c) *Status and incentives for paid PHC staff;*

There is a substantial difference in status between the Medical

Officers and other staff working in PHC programmes on the one hand, and their colleagues in the curative services on the other.

The difference in monthly income between curative medical staff with flourishing private practices and those working on preventive programmes who have to live on very modest monthly salaries can well be imagined.

Status and income are the justifiable desires of every professional. Given that such job difference exists, the preventive field is naturally the last choice for individuals from the medical and paramedical background. This obviously affects the quality of workers available for an important area like PHC. In these circumstances the inevitable conclusion is that even though these professionals may be convinced that an effective PHC programme is the best way to raise the health standards of the community, motivating and interesting them in the field is very difficult, especially when their prospects are so poor when compared with their curative counterparts.

Taking this into account and given the paramount importance of PHC, the policies of the Government should be amended to provide equal status to workers on the preventive side. Their salaries and the facilities available to them should be improved to reflect the amount of hard work a fully operational PHC programme requires. In addition an attractive career structure should be introduced which is based not only on seniority but on performance. Professionals producing good performances should be sent for higher training or educational qualifications in their respective fields. This would not only help deserving professionals to climb the career ladder, but would also help the entire health service, since the improved talents of these individuals could be utilised more effectively. It would also instil a competitive spirit in the entire field, thereby promoting better performances.

5.3.2. Incentives for PHC Volunteers

The voluntary health workers are the most sensitive category of PHC staff. The effectiveness of the whole programme is based on their interest and application.

Because of their numbers (1 per 30 families) paying them would not be possible but an equally good incentive could be offered to them in terms of recognition as community representatives and by tackling their legal problems and requests on a priority basis. This again would only be possible through a policy decision by the Government and directives to all relevant departments.

5.3.3. Effective Administration

Since the success of a PHC programme requires the collaborative effort of various sectors, strong supportive general administration can play a very important role. Effective medical administration is also required.

5.3.4. Use of Influential and Respected Community Leaders

The programme can be affected and greatly helped by the use of influential community leaders, both before it starts and later when it is operational. Developing a good relationship with these individuals should therefore be one of the aims of the PHC workers. Motivation of the community is a continuing activity and depends on the active participation of BHU staff.

5.3.5. Integration of PHC into the existing Health Services

PHC programmes like the one being discussed are always developed with the hope that the staff trained (CHWs) and those employed (CHSs) will ultimately act as the outreach services of the health facilities, improving the basic health knowledge of the people and bridging the gaps between the community and their health facilities, and thus extending basic health services to every doorstep.

Such hopes will remain impossible until there is complete integration. There is no place for vertical programmes in a PHC programme.

Chapter - 6

THE PHC PROGRAMME IN HAZARA DIVISION

PHC seems a simple approach to a complex problem. However if implementation is not handled in a systematic and proper way the reverse is true. Every factor in the success of PHC is linked to the others, and a weakness anywhere can hold back progress considerably.

6.1. Constraints

(i) There was no official policy or support for the implementation of PHC until the programme was underway;

(ii) There were budgetary constraints, and minimal resources were available;

(iii) Medical and paramedical staff had received indifferent training and no orientation towards prevention;

(iv) There was no career stability for health staff; the temporary nature of the job, with no hope of performance-based promotion and thus frequent staff changes, nullified all the time, effort and money spent on such people;

(v) Strong cultural and religious barriers;

(vi) Tribal groupings and sub-groupings and different political affiliation in a single refugee village, making free movement and communication very difficult.

6.2. Fears

(i) Voluntary staff:

Almost every sector had serious doubts about how long voluntary staff would work; it was generally felt that they would not last long, would not work as desired and that monitoring, supervising and controlling them would be next to impossible.

(ii) Creation of mini doctors:

The inclusion of a few basic medicines in the CHW kits created an apprehension that a new breed of mini doctor was being created and would lead to an enormous increase in quackery by legalising unqualified medical practice.

(iii) Threat to position of BHU staff:

Some sectors of the medical services felt that the concept of CHWs would compromise their position in the field; they thus felt the programme would be a threat to their authority in the medical field.

6.3. Overcoming Constraints and Fears

The health sector of ARO Hazara therefore faced a challenging situation. On the one hand the medical and paramedical staff did not have the desired training or attitudes. They were taking the job on a temporary basis, looking out for better opportunities and thus were not seriously committed initially. Moreover, there was support in terms of policy or administration, and a different community to deal with. On the other hand there was a conviction that the programme could be an asset for the existing health services.

Accepting the challenge, there was no alternative but to create locally all the factors thought necessary for success. ARO Hazara therefore began with interest and enthusiasm.

(i) Local ARO General Administration and Other Departments:

By developing relationships with the relevant local offices and explaining to them the advantages, aims and objectives of the programme, the collaborative effort so necessary for the success of a PHC programme was achieved.

(ii) Local Medical Administration and In-service Training:

It has always been policy within the ARO Health Sector in Hazara to create an atmosphere which ensures that the responsibilities fixed for every category of staff are fulfilled in accordance with the policies planned and laid down. This has been possible through motivation and by providing staff with the security and facilities needed to fulfil their duties, as well as maintaining the discipline and strict supervisory control that is so necessary in temporary situations. In this way the staff realise that much is expected from their department, but that there is also a strong support for them from these circles.

It was realised locally that, while the training of the BHU staff in preventive medicine and public health was below the desired levels, other managerial qualities and in particular the administrative skills to make the best use of each staff member were virtually non-existent.

The importance of this leadership concept cannot be over emphasised, for in a PHC programme it is the Medical Officers who, as the team leaders, not only have to lead, organise and coordinate the activities of all staff in their health facilities, but also have to develop good relationships with the community and the staff of other departments to achieve better overall results.

Needless to say, without administrative authority and know-how, without the requisite skills and attitudes, better overall results are not possible.

To strengthen these aspects among the Medical Officers in particular and the health staff in general, more powers were delegated to the Medical Officers, enabling them to exercise greater control over their staff and to be more effective in various other fields. It was also decided, in collaboration with the ARO general administration, that the Medical Officers would have a say in health issues relating to other departments.

At the same time, in-service training proceeded through seminars, workshops, continuous emphasis on preventive care and on-the-spot instruction during supervisory visits to health facilities. It was made clear to the Medical Officers that producing results was their responsibility.

All the above effort helped improve the knowledge, attitudes and skills of the health staff, not only in the theoretical aspects of preventive medicine but also in their ability to implement these concepts in practical situations as managers.

(iii) Motivation of Community and BHU Staff:

Long before the process of community and health staff motivation was taken up by SCF, preparations for the operations of SCF's mobile teams had been initiated by the ARO Health Sector. Word was spread through the community at Jirgas (meetings) with influential and respected members of the refugee villages, stressing the importance of people becoming involved in their own health care. The staff of the health facilities were briefed about the programme through visits by their supervising authority, with emphasis on how helpful the programme would be to them in performing their duties. Obviously the main job of almost door-to-door motivation was done by the SCF mobile teams.

Between the start of this motivational phase by SCF and the programme becoming operational in BHUs - i.e. when the CHSs had been employed and medical kits distributed among the CHWs - it is SCF's policy to keep the Medical Officers and other BHU staff informed about their activities. In turn the Medical Officers are responsible for discussing this information with the FSMO. During this phase all staff acquire a fair understanding of the programme, which helps in their motivation and later in the integration of the programme into the existing health services. As a result the integration of the programme has never been a problem in Hazara.

The existing health staff accepted the CHSs and CHWs and started working in harmony with them. At this point it has to be admitted that initially both the health staff and the community had doubts about the programme, but as time went by and the effects of PHC started to be felt, with activities being carried out in a planned manner, the health staff were relieved of the extra job of promoting interest and enthusiasm for the programme.

When basic health services started being delivered to their doorsteps, much to their satisfaction, the community also started becoming more and more convinced, and this too promoted participation.

(iv) Concept of Voluntary Labour/Incentives for CHWs:

One of the main worries was that the volunteer CHWs would not stay in post for long, since no financial incentives were offered to them and especially in view of the fact that a large majority of adult Afghans work locally as labourers or have some other job. On the other hand, the job required of a CHW is not very time-consuming

Chapter - 1

AIMS AND OBJECTIVES

This paper discusses the effectiveness of the concept introduced by Save the Children Fund (UK) - SCF(UK) - for implementing Primary Health Care (PHC) with the help of volunteer labour (Community Health Workers or CHWs) and the establishment of a link between the health facilities and the community by means of a Government employee, the Community Health Supervisor or CHS. Taking as an example the Haripur, Hazara, PHC Programme of the Afghan Refugee Organisation (ARO), the paper, through a discussion of various supervisory and managerial systems of this programme, aims to demonstrate to all those interested and involved in the implementation of PHC, how to integrate in health programmes and effectively utilize the community services i.e. trained volunteer labours or CHWs, for improving the provision of health care to the client communities. The paper also provides an insight into the issues and problems that usually surround a PHC programme at different stages of its implementation, and how these can be overcome with a proper approach. It outlines factors and needs that exist nationally (in Pakistan) and internationally for the successful implementation of PHC.

from day to day and can be managed very effectively with minimum alteration to the daily routine. The ARO Health Sector in Hazara was therefore quite optimistic. Its views were based on another school of thought; namely that incentives do not necessarily have to be in the form of money or monthly salaries. Equally good incentives can be made available in the form of recognition as respected community representatives, ensuring that their private legal problems are dealt with on a priority basis, and that recommendations regarding the community are considered seriously by the appropriate authority.

With a supportive colleague in the ARO District Administration, a policy was worked out to cover these points as incentives for the CHWs, and a directive was then passed down to the field and all the other relevant sectors. This had a great impact and after approximately three years out of a total of 350 only a handful of CHWs had left (10-12). Even these had gone for genuine reasons, such as going for Jehad (Holy War) or moving to take up employment in a distant area.

6.4. Monitoring and Uses of CHSs and CHWs

BHU staff perform their duties in accordance with a weekly routine set out for each one of them.

The routines have been so designed that, besides working at the BHU, the staff spend an equal amount of time making home visits and doing outreach work.

The weekly routine chart, which is as under, outlines the routine for each staff member; such charts are displayed in the clinics and are strictly followed.

Apart from the Medical Officers who do home visits once a week, and the CHSs, who do it daily, the rest of the staff have 2-3 days of outreach work out of a total of 6 working days/week. As is pointed out in the chart, at the end of the day's work, that is the last 1/2 hour of working time, all the staff members of the BHU sit together to conduct a daily coordination meeting in which, under the guidance of the Medical Officer, they analyse the day's work and plan for tomorrow.

CHART B: WEEKLY ROUTINE CHART

Staff	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Last 1/2 Hour Daily
MO	AT BHU	AT BHU	AT BHU	AT BHU	AT BHU	OUTREACH	DAILY COMMITTEE COORDINATION
LHV	ANTENATALCLINIC AT BHU	OUTREACH	UNDER 5'S CLINIC AT BHU	OUTREACH	AT BHU		
VACCINATOR	AT BHU	OUTREACH	AT BHU	OUTREACH	AT BHU	OUTREACH	
MIDWIFE	AT BHU	OUTREACH	AT BHU	OUTREACH	AT BHU	OUTREACH	
MALARIA SUPVR/ SANITARIAN	OUTREACH	AT BHU	OUTREACH	AT BHU	OUTREACH	AT BHU	
DISPENSER	AT BHU	AT BHU	AT BHU	AT BHU	AT BHU	AT BHU	
CHS	OUTREACH	OUTREACH	OUTREACH	OUTREACH	OUTREACH	OUTREACH	

TIMINGS

	SUMMER	WINTERS
Working hours	7.30 am to 2 pm	8 am to 2.30 pm
Outreach hours	8.30 am to 1 pm	9 am to 1.30 pm

As paid employees of the BHU the CHSs, just like other medical and paramedical staff, have to work exactly according to their job description, abiding by the rules and regulations and the routine of their BHU.

CHSs are told that one of their main jobs is to develop a relationship with their CHWs. Compliance with the various requests of the BHU forms the criterion on which the efficiency of a CHS is judged.

The routine of the CHSs in the BHU of Hazara is as follows: the CHSs visit the BHU early in the working day to mark their attendance. After receiving instructions from the Medical Officer they leave the BHU for their outreach activities in the field, in accordance with a planned schedule (see below). Having finished they return to the BHU at midday and inform the Medical Officer about what they have done.

In the last working hour all the BHU staff sit together to discuss the day's work. After analysing this, the MO allocates responsibilities to each staff member for the next day, since of course most of the outreach jobs have to be entrusted to a CHS.

The CHWs do not have a fixed routine. They attend the BHU as and when they need to. They are supposed to work in their free time and their work is supervised and monitored by the CHS. The CHWs, however, do have to attend the BHU for an hour or so at the end of each month to attend the monthly meeting (see below).

CHART C: COMMUNITY HEALTH SUPERVISOR MONITORING CHART

BASIC HEALTH UNIT NO. 8							REFUGEE CAMP NO. 8
NAME OF CHS - ASIF							
NAMES OF THE MEMBERS OF THE HEALTH COMMITTEE							
	SHER			IMDAD		RIAZ	
CHW A	CHW B	CHW C	CHW D	CHW E	CHW F	CHW G	CHW H
01-01-87	02-01-87	04-01-87	05-01-87	06-01-87	10-01-87	09-01-87	08-01-87

The CHSs have a daily outreach activity schedule and the following chart has been devised by the Health Sector of ARO Hazara to monitor their activities in the field.

As can be seen, Chart C gives the name of the CHS and the names of Health Committee members who are well known figures in the refugee community. It also records the names of the various CHWs who reside in the area of the

particular Health Committee member. Under the name of each CHW are the dates on which a CHS will be visiting him. These dates are planned with the help of Chart D (See below).

The chart shows where a CHS will be during his outreach activities on a particular date, making it easy for the supervising officer to monitor his activities. If for any reason the CHS is not able to stick to this routine, he has to inform the MO in advance or immediately afterwards, giving the reason for doing so.

The chart also helps in referring patients from the BHU to a CHW.

The CHS is supposed to visit at least one CHW each day, so that by the end of each month he has visited, at their homes, all the CHWs under his control.

6.4.1. The Monthly PHC Activities Chart (Chart D)

The use of the monthly PHC activities chart, besides helping the health staff in various ways to improve the health care delivery systems, has been of immense importance in integrating the community services into the existing health services.

An example is this monthly chart for January covering three CHWs:

CHART D: THE MONTHLY PHC ACTIVITIES CHART *

Name of CHW	Member of Health Committee	DR	MN	F	TB	Houses with latrine	Houses without latrine	D. Water sources in houses TW	SW	UI with TT CBA	UI U5	B	D	Def AN	IP
Malook	SHAFIQ	40	20	30	15	0	30	0	30	15	20	10	4	10	4
Aqa	"	10	10	20	10	10	20	20	20	5	7	3	1	8	2
Niaz	"	30	15	10	8	20	10	10	10	45+	45	6	3	11	4

*** ABBREVIATIONS:**

DR	=	Diarrhoea	SW	=	Shallow well	D	=	Deaths
MN	=	Malnutrition	UI	=	Un-immunised	Def	=	Number of defaulters
F	=	Fever	TT	=	Tetanus Toxoid	CBAs	=	Women of child-bearing age
TB	=	Tuberculosis	U5s	=	Under 5 children	AN	=	Antenatal clinic
TW	=	Tubewell	B	=	Births	IP	=	Immunisation programme

6.4.2. Advantages and Uses of Chart D

a) *Identification of Prevalent Disease Conditions*

Besides giving the location, nature and extent of the different prevalent diseases, it also provides important information for each CHW's area on their components of PHC like sanitation, water supply, immunisation, etc.

The chart shows, for instance, that among the families covered by Malook, a CHW who lives in the area of Health Committee member Shafiq, there have been 40 cases of diarrhoea, 30 cases of fever and 15 cases of tuberculosis (the latter diagnosed by the BHU, which then informs the CHW), in the month of January.

The sanitary situation in the area of this CHW is poor. None of the 30 houses has a latrine, and all households use shallow well water for drinking purposes.

There are 15 women of child bearing age who have not been fully immunised against tetanus and 20 children under five who have not been immunised.

For the purposes of this chart, any CBA woman or under five child who is not fully immunised is shown as unimmunised. A fully immunised CBA woman is one who has received two doses of tetanus toxoid; a fully immunised under five child is one who has received one dose of BCG, three doses of polio and DPT vaccines and one dose of measles vaccine.

There have been 10 births and 4 deaths in this area, and the CHW has 10 defaulters from the antenatal clinic and 4 from the immunisation programme.

It should be noted that the figures for prevalent diseases are taken as rough indicators, not as actual diagnosis or incidence; they are based on the information in the CHW's monthly disease reports.

b) *Indications of Cause of Health Problems*

As can be seen in the above example, the number of diarrhoea cases is highest in the area of CHW Malook, and if we go further down the line, examining other PHC components in his area, we find that the number of houses without latrines in his area is also the highest and that the majority of houses use shallow well water for drinking purposes.

Taken together, these two factors could well be the cause of the high incidence of diarrhoea in his locality.

c) *Relevant Health Education and Effective Utilisation of Outreach*

Health Education has numerous benefits, but it becomes much more effective in the longer term when it is related to the prevailing health situation.

The importance of health education, planned outreach activities, community participation and other factors in a PHC programme have been explained to the health staff with the help of the following concept! if health education is regarded as the essential nutrient or blood of a PHC programme, planned outreach activities can be seen as the blood vessels through which the blood is supplied to the masses (the tissues) at grassroots level, by the heart or pumping organ of PHC (the health staff). The stimulus for the contraction of the heart

comes from the participation of the community. The stronger the stimulus, the more forceful the contraction, and thus the provision of the essential nutrient to every part of the community or body.

In this concept:

1.	Body	=	Community
2.	Heart	=	Health Staff
3.	Pacemaker	=	Community participation
4.	Blood	=	Health Education
5.	Blood vessels	=	Outreach activities
6.	Tissues	=	Masses

The information recorded in Chart D helps the BHU staff to plan and utilise their outreach activities effectively, thus educating the community on relevant health topics and improving their basic health knowledge.

The way the outreach activities are planned is as follows: every column of the chart is the responsibility of a different member of the health staff. For example, in the above chart diarrhoea and malnutrition are the responsibility of the LHV, since most of the diarrhoea and malnutrition affects children under five who are routinely seen by them. Similarly, the information in the columns for fever, latrines and water supply relate to the job of the malaria supervisor/sanitarian, while that in the column for immunisation falls within the domain of the vaccinator.

Knowing the columns most closely related to their jobs, the different categories of health staff can easily identify the areas which they need to visit as soon as possible, or on a priority basis, selecting the area where the situation is worst for their first visit. For example, if the above chart for January was being used to plan outreach activities for February, the LHV would pay her first visit to the area of CHW Malook, because the numbers of diarrhoea, malnutrition and unimmunised CBAs (40, 20 and 15 respectively) are the highest.

During her visit she would give health talks on: (a) diarrhoea, and the preparation and use of oral rehydration salts, with practical demonstrations; (b) malnutrition, after studying the nutrition aspects in the locality and determining the cause she would also motivate the families to go for regular follow up examinations at the growth monitoring clinics; (c) immunisation, stressing its importance and convincing the women of child bearing age to get themselves fully immunised.

Her next visit should be to the area of CHW Niaz, where these conditions are the second worst, and the last should be to CHW Aqa's area.

Likewise, the malaria supervisor/sanitarian's first visit should be made to the area of CHW Malook, since the numbers of fever cases, diagnosed TB cases and houses without latrines are the highest here (30, 15 and 30 respectively). His next visit should be to CHW Aqa's locality, where these figures (20, 10 and 20 respectively) are the second highest.

During his visits the malaria supervisor would teach people about the prevention of malaria, and make blood slides of suspected cases. He would stress to those diagnosed as having TB the importance of regular long term treatment and sputum follow up examinations. He would also give a talk on sanitation, motivating people without latrines to get them made.

These outreach and health education activities are recorded and displayed in each staff category's room (here, for example, the LHV's) with the help of the following chart:

CHART E: OUTREACH AND HEALTH EDUCATION ACTIVITIES - LHVs

MONTH	1ST WEEK	2ND WEEK	3RD WEEK	4TH WEEK
January	CHW Malook Date: 02/01/88 Topics: ORT Malnutrition Immunisation antenatal clinic defaulter	CHW Niaz Date: 09/01/88 Topics : ORT Malnutrition Immunisation	CHW Aqa Date : 16/01/88 Topics : ORT Immunisation and defaulter tracing	
February				
March				

Using this chart, each member of staff can be asked to justify their visits to a particular locality and the topics discussed. Ideally these visits should be in the order of importance shown by the PHC activities chart (D) - that is, the CHW area with the most problems should be visited first and the topics discussed should be appropriate to these problems.

The advantages of such outreach and health education activities, planned on the basis of information supplied by the community, are three-fold:

(i) For the staff of the health facility: effective utilisation of outreach programmes can achieve an appreciable impact, and the staff can thus fulfil their duties more easily and to greater effect.

(ii) For the supervising authorities and CHWs: as the health staff pay visits to different CHWs on the basis of their reports in the previous month, they are able to assess the accuracy of these reports. If the reports are correct, they can take appropriate action, which not only improves the health situation in the area but increases the credibility of the CHW and encourages him in his work. However, where reports are incorrect the weaknesses of the particular CHW are noted and the visiting health staff member, besides explaining to the CHW, informs the CHS of the need to strengthen these aspects of the CHW's work.

(iii) For the community and the PHC programme: planned visits by health staff and timely action can prevent various problems and thus improve the health status of the community. They also encourage and motivate the community to take part in their own health care and to cooperate more with the CHW.

d) *Indicating Monthly Improvement*

Studied month by month the charts show any improvement or deterioration in the situation, depending upon whether or not the health facility has taken timely action. As an example, in the above chart for January the number of unimmunised under fives with CHW Niaz is 45; if the MO has taken timely action through the outreach activities of his vaccinator, this figure should show a decrease in February and March.

e) *Accurate Information on Vital Statistics*

The columns for births and deaths alongside the name of each CHW provide information which is very reliable and current, and can thus be used in conducting different epidemiological studies and taking timely action.

f) *Defaulter Tracing*

The chart also records the numbers of defaulters in various BHU programmes. Thus defaulter tracing and motivation, which before the integration of community services was a big problem, has become very much easier since integraton.

6.4.3. Control and Monitoring of CHWs

The tasks which the CHW is expected to perform are laid down in his job description ("Motivation, Training and Selection Phase"). This has been designed by SCF so that the fulfilment of these duties requires only the minimum time away from his normal daily routine, and by sticking closely to the selection criteria it is possible to ensure that everyone chosen as a CHW has enough free time to do the job required of him. However, in handling volunteers it is also important to ensure that they do not feel tied down or overworked by using their assistance in too many programmes. It is better to introduce programmes one at a time, according to the needs of the situation, and asking them to utilise only their free time.

6.4.4. Monthly Meeting CHWs

With the general attitude in mind, the Health Sector is very firm about the attendance of every CHW at the monthly CHW meeting. This is held in the BHU at the end of each month and is conducted by the MO in the presence of the CHSs.

At these meetings all the activities carried out by the CHWs, which are recorded on the various forms devised by SCF (see Recording and Reporting Systems - "Motivation, Training and Selection Phase") are passed on to the CHS, who checks them for accuracy, etc.

Drugs are distributed to the CHWs to replenish the stock in their medical kits.

A discussion is then held between all the participants on various health and other problems.

The MO instructs the CHWs, based on:

i) the information that reaches the MO about the health situation of the area during the month;

ii) the performance of CHWs in the previous month and improvements made, or otherwise.

A system (see Charts D and F) has been devised by the ARO Health Sector Hazara to monitor the activities of CHWs in the field and to give an idea of the health situation of the thirty families for which each CHW is responsible.

This monthly chart records alongside each CHW's name the various components of PHC as well as the prevalent diseases. By looking at the chart one can see not only the rough incidence of these diseases in a particular CHW's area but also an indication of the causes.

For example, the number of diarrhoea cases in a particular CHW's area may be 80, which is high. When one looks further along the chart one can find possible causes which could be drinking water and poor sanitation.

The information on various diseases recorded on these charts is based on the disease report forms (devised by SCF) that each CHW uses during the month and delivers to the CHS at the monthly meeting. When the information is recorded on these charts it shows:

(i) the type of health problems

(ii) the area in which they occur

(iii) the probable causal factor

It is then easy for the MO to decide where and how to apply his resources.

Based on the information provided by these charts, the home visits routine of the CHS (see dates in Chart C) and the MO and the outreach ac tivities of other staff categories are planned for the month to follow. Areas with particular problems or high incidence of disease get priority visits. This ensures effective utilisation of outreach activities, with visits being made to the areas which need them most.

The monthly charts are displayed by monthly sequence in the BHU, so that during supervisory visits made by the provincial health authorities it is easy to judge whether any improvement has been made or not. For instance, if the number of unimmunised children with a particular CHW is high in the month of March, the chart for April should show a considerable decrease in this number if the MO has taken timely action.

It is not possible for mid-level or senior level managers to go into the details of the work done by each CHW, but it is necessary to know which areas are strong or weak so that action can be taken accordingly. The ARO Health Sector Hazara has therefore devised the following system (see Chart F, below).

The number of births speaks for itself, as a problem or otherwise.

CHART F: MONTHLY PRIMARY HEALTH CARE RETURN

NAME OF CHS	NO. OF BIRTHS	NO. OF DEATHS	NO. OF MARRIAGES	REFERRALS FROM BHU	REFERRALS FROM CHW
SHER ZAMAN	3	0	5	20	10
MALOOK	1	10	0	30	2

The number of marriages keeps the BHU informed about the need for tetanus immunisation.

The number of referrals from the CHW can show a variety of things:

(i) Average numbers indicate that the situation in the area is normal and the CHW is working well;

(ii) High numbers indicate that a health problem has cropped up in the area and that the CHW is working well;

(iii) Repeated low referrals indicate low performance of a CHW;

(iv) Repeated high referrals could indicate good performance or falsification of records in some instances.

Based on the above general information a mid-level manager can go into the details of the problem areas, using the information available in the BHU during his supervisory visits and can then issue on-the-spot directives.

6.4.5. Home Visits of MO and Refugee Village Administrator (RVA) to a CHW

Once a week the MO and the RVA visit a CHW. This system serves a dual purpose of motivation and supervision.

The RVA's role is to identify and try to solve the problems, if any, faced by the CHW or his 30 families. The MO makes an informal assessment of the health situation and the performance of the CHW, as well as going through his records.

These weekly visits are planned by the MO in accordance with the information given in Chart D of the previous month; problematic areas are visited first.

In addition to the benefits in terms of assessment, these visits of two leading officials of the refugee village help to generate interest in the CHW, who also gets a chance to have his problems (health and others) solved, if this is within the powers of the MO and RVA.

6.4.6. Roles of CHSs and CHWs

The main roles of the CHSs and CHWs are in health education and the promotion of community participation in the various preventive health programmes of the BHU. The basic curative services which they provide in the field, using the medical kits they are issued with, are designed only to:

a) increase their credibility as health educators/motivators, so that they can convince and motivate people more effectively;

b) provide some basic first aid until the patient can reach a health facility.

The roles of CHSs and CHWs fall under two major headings, 'Routine' and 'Planned' Activities.

(i) *Routine Activities:*

The system is so designed that, if it is working properly, health education becomes an ongoing process. Every patient who seeks the help of a CHW or is referred to him by the BHU receives not just the basic first aid but also education for himself and his family about the prevention of that disease. As many people with different conditions seek the help of the CHW, the community becomes increasingly educated in the prevention of prevalent diseases.

The CHSs address patients attending the BHUs at peak hours, imparting health education on an important PHC topic such as immunisation, oral rehydration, drinking water and sanitation, or prevalent conditions like malaria and tuberculosis. Topics are also chosen by the MO according to the season and disease prevalence, and the CHSs then communicate the appropriate message to the community themselves or through the CHWs.

The CHWs pay routine visits, which are planned after studying Chart D. The CHWs discuss with the family one or two of the basic components of PHC, giving practical demonstrations where necessary (eg. how to make ORS).

The CHWs are instructed to choose topics which are of relevance to the particular family they are visiting. In addition, the CHWs advise the families on any topic given and explained to them by their CHS, who in turn is instructed by his MO.

Chapter - 2

THE REQUIREMENT FOR PRIMARY HEALTH CARE

The first United Nations (UN) conference on PHC, jointly organised and sponsored by UNICEF and World Health Organisation (WHO), was held at Alma Ata, USSR, between 6-12 September 1978. The conference considered the close relationship and interdependence of health with social and economic development, and the constraints imposed by limited resources, particularly in developing countries. It also addressed the various beliefs and attitudes that exist towards health. The conference defined PHC as:

"......essential health care, that is based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community, by means acceptable to them, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination".

The WHO proposed the following as essential components of the PHC approach:

1. Health education;
2. Safe water and sanitation;
3. Nutrition;
4. Immunization;
5. Mother and child health care including family planning;
6. Treatment of common diseases and injuries;
7. Control of local endemic disease;
8. Provision of essential drugs.

PHC thus seeks to address the main health problems of the community and by prevention, promotion, rehabilitation and basic curative interventions to improve dramatically the health status of the community. As these services evolve from and reflect the economic condition and social values of the community, they will (of course) vary from place to place. Therefore mechanisms of implementation need to be adapted to the particular community, in line with economic considerations and social values.

The CHWs provide basic curative services, using the medicines and equipment contained in their medical kits. They are instructed not to issue more than two days' supply of drugs. The range and quantity of drugs supplied in the kit ensures this (see medical kit in phase I).

The CHSs/CHWs also perform an important role in collecting medical information on subjects like births, deaths, rough disease incidence and any other PHC components such as water supply, sanitation, etc.

They also assist in tracing defaulters and in the BHU's preventive activities.

(ii) *Planned Activities:*

Certain planned activities, depending upon the requirement of the area, are also carried out through the CHS and CHWs. For example:

- mass immunisation campaigns (see below);
- oral rehydration campaign;
- registration of under 5s.

6.4.7. Use of Influential Refugee or Health Committees

Health committees have been formed for each BHU, comprising respected and influential refugees of the area, the MO and the RVAs. The role of these committees has already been discussed. It has to be admitted that this part of the programme is not as well developed as the others, for the following reason: the true leaders of the refugees are not always available and, because of their circumstances, regular attendance is not always possible. However, having said that, the health committees have been used effectively at times to propagate programmes such as mass immunisation, gaining access to difficult areas and overcoming problems pertaining to the community.

Chapter - 7

IMPACT OF THE PROGRAMME

The period of approximately two years since the Hazara PHC programme became fully operational is probably too short a time for any results to show in terms of improvement in statistics, such as Infant Mortality Rate (IMR). Moreover, such improvements stem not only from the efforts of the health sector, but also from other developmental processes.

Another characteristic of the initial stages of a PHC programme is a rapid increase in information from every sector of the population. This helps to identify areas for improvement, but actual development takes time and obviously cannot provide an immediate impact.

In fact, with increased and improved information, especially in areas where the development processes cannot keep pace with the various diseases, deaths, etc. are liable to go up initially.

Assessment is further complicated since reliable data are not available for the period before the PHC intervention. This is the case with the Afghan Refugee Health Programme.

While it is true that PHC programmes take a long time to show impact, I would argue that the indicators of success are different at the different stages of the programme.

Taking these indicators in chronological order i.e. in line with the time span of a PHC programme they are:

(i) Success in motivating community and health staff to accept and understand the programme;

(ii) Improvement in quantitative and qualitative performance of health facilities;

(iii) Change in attitude of health staff;

(iv) Success in overcoming constraints and fears;

(v) Change in attitude of the community;

(vi) Improvement in basic statistics.

These indicators are discussed below as they apply to the PHC programme in Hazara.

7.1. Motivation of Community and Health Staff

The nomination of CHWs and CHSs by the community in response to the efforts made by the SCF mobile teams indicates initial success. The ease with which the staff of the health facilities accept these categories (CHSs and CHWs) and started working in harmony with them indicates a successful integrative process obviously the result of motivated staff at the health facilities.

7.2. Improvement in Performance of Health Facilities

Delivery of health services to the client population has improved in a very short time.

Qualitative improvement was seen in the number of refugees reached by our BHUs in preventive programmes. This was only possible due to the cooperation and work done by the CHWs. From the administrative point of view, use of smaller and more easily quantifiable and identifiable groups made planning and implementing different programmes very much easier.

The mass immunisation campaigns can be given as an example:

a) 98% BCG scar coverage has been achieved in the area. These figures were provided by UNHCR after a random survey. The way in which the campaign was carried out is an example of how systematically such activities are carried out with the help of CHSs and CHWs:

   (i) Initially all the CHWs were asked by their CHSs to count the under 5s and females aged 15-45 years in their 30 families;

   (ii) The results were kept in the BHU; when the total numbers for each CHW were known, the campaign was planned and started;

   (iii) Having previously informed the CHWs, the MO sent his vaccinator to that CHW, who would have gathered all the people of target group at one spot for immunisation. With the survey results available to the vaccinator, he would know how many had not turned up for immunisation and would ask the CHW to produce them.

   Having finished all the work with the first CHW, the immunisation staff would then move on to the next. In this way all the areas covered by CHWs were immunised.

   The procedure was then repeated at monthly intervals until 3 doses of DPT and polio were completed.

   Duplicate cards were made, one card being handed over to the CHW and the other held at the BHU under the CHW's name.

   The CHW was told that children who were under 9 months at the time of the campaign should be produced later, when they reached this age, for measles vaccine. Since the cards were available to both CHW and BHU this never became a problem.

   With regular information on births and marriages arriving at monthly intervals from all the CHWs (see Chart F) it was easy for the MO and the vaccinator to keep up to date the numbers of children needing to be immunised. In this way, maximum immunisation coverage has been provided to the client population, with their cooperation.

b) Similarly, with the cooperation of the CHWs, large numbers of children have been registered in the BHU under 5s clinics for the purpose of growth monitoring and preventive or curative interventions as required. Thus a very vulnerable age group is helped.

In a society where a large majority is illiterate and in a programme where no supplementary feeding is given on attendance at the health facility, such a response is satisfying and could only have occurred through the cooperation of the community representatives, the CHWs.

c) Finally, basic curative services are available round the clock on the community's doorstep.

7.3. Changes in Attitude of Health Staff

As has already been said, to begin with, the staff were less than fully convinced about the effectiveness of the programme and how much it would help them in doing their jobs.

In the initial phase they went through a period of intensive work to reach most of the people, but when a satisfactory level of health service provision had been attained and things became more systematic and easy to plan and conduct, the staff were relieved of unnecessary job pressures and became very interested in and supportive of the programme.

During the outreach activities almost every staff category initially identified areas where the CHWs were not trained due to oversight, new arrivals or some other reason. They soon began to request the immediate provision of a CHW, realising how much he could help them in carrying out their duties.

Moreover, whenever the programmes of different BHUs were being compared, the usual explanation given for poor performance is weakness among the PHC staff, the CHSs and CHWs. This shows that the staff were beginning to realise the importance of community participation and made an active effort to achieve it.

7.4. Success in Overcoming Constraints and Fears

The CHSs are nominated by the community. This, as well as the criteria and process of selection, ensures free access for the individual who is ultimately trained and employed as a CHS.

The Afghan extended family unit is roughly 30 houses; this is why one person per 30 families is trained as a CHW, thus ensuring that the CHW will have easy access to the families who have nominated him.

This method has overcome the constraints to mobility and communication caused by cultural, religious and tribal groupings and different political affiliations in a single refugee village.

Moreover, the curricula and teaching methods are so designed that the simple health messages can easily be understood and communicated to the community even by illiterate people.

The changing attitudes of health staff have already been dealt with in detail.

The initial fears that were associated with the programme have also proved to be incorrect. Only a handful of CHWs have left and all for genuine reasons. The large majority is still working enthusiastically. Quackery has not flourished; in fact, the CHWs have proved helpful in identifying quacks and actually reducing illegal medical practice.

7.5. Change in Attitude of Community

The attitude of the community towards the programme in general has shown a gradual improvement over time, as indicated by:

(i) demands from different sectors of the population for preventive programme like immunisation, under 5s registration, etc.;

(ii) rapid nomination of CHWs and request for training in areas where the CHW could not continue in his job and had left the refugee village. Strong complaints if there was no response to request;

(iii) assistance from the community in identifying illegal medical practice, clearly showing their greater reliance on the BHUs and CHWs;

(iv) easier access for health staff to private homes and the female population;

(v) flexibility in the strong cultural traditions is shown by the fact that a large number of females come now to use preventive health services like antenatal registration and TT immunisation, and in some areas females have been nominated for volunteer community work.

All these points indicate a positive change in the belief and attitude of the community towards health care.

7.6. Improvement in Basic Statistics

In a short span of two and half years we have so far achieved the first five steps or indicators of success of our PHC programme. As far as the sixth step is concerned, improvements in basic statistics are heavily reliant on the different development processes, which, for obvious reasons, are very slow in the Afghan refugee situation. Moreover, no such statistics are available for the period before the intervention of this programme, which makes assessment complicated.

7.7. Impact on Existing Health Programmes

The aim of this paper is to examine and discuss the provision of PHC by the health facilities with the help of integrated community services (ie. the concept of CHWs and CHSs), and also to provide a working model for the guidance of all agencies interested in implementing PHC with the help of community services.

The Afghan Refugee Health Programme consists of the following:

1) Tuberculosis control programme;

2) Malaria control/sanitation programme;

3) Immunisation programme;

4) MCH services and oral rehydration therapy programme;

5) Basic curative services.

Each of these five areas is examined below, with a brief discussion of general policy in each area, followed by the difficulties in implementation before the intervention of the community services, and finally the role of the CHWs in improving the situation. It should be mentioned that after the integration of the community services the name of the CHW was included in every recording and reporting system of the health programme.

7.7.1. Tuberculosis Control Programme

The infectious nature of tuberculosis, especially considering the over crowded living conditions of the refugees and its high incidence and prevalence amongst refugee communities, has made tuberculosis an area of prime importance in the Afghan Refugee Health Programme. Through active case detection and effective medical treatment the health sector has been able to bring tuberculosis under reasonable control.

The policy with regard to tuberculosis control is to detect through sputum examinations as many open cases of pulmonary tuberculosis as possible, since these are the spreaders of the disease. Once such cases have been detected they are registered in the health facilities for treatment with effective drugs as a sputum negative, so as to check the spread of the disease in the community. The treatment is then continued for a number of months (depending upon the treatment regime) to radically treat the individual patient.

(i) *Difficulties in implementation:*

Case detection: being conscious of the high incidence of the disease and its infectious nature, the Afghans did present themselves to the health facilities for examination, but even this needed a lot of improvement, especially in investigating the contacts of sputum positive cases.

Treatment: The main problem in the long term treatment of tuberculosis patients was that significant numbers of patients would discontinue treatment after the initial two to three months, usually when the symptomatic stage was over. Amongst the registered cases there were also large numbers of defaulters who, for one reason or another, would fail to collect drugs for some period and would thus discontinue treatment for that period before starting again.

Follow up examinations: to judge the progress of individual registered cases it is important to have periodic follow up examinations of sputum and chest X-ray (quarterly). It was difficult to convince patients of the need for regular follow ups.

(ii) *Role of CHWs in TB programme:*

To overcome these difficulties the community needs to be given a thorough understanding of tuberculosis. As has been mentioned, due to a variety of reasons, tuberculosis is a priority area of the PHC programme for the Afghans. During their training programme, therefore, the CHWs and CHSs are taught about the infectious

nature and the symptomatology of the disease, and the importance of the regularity and duration of treatment as well as follow up examinations. Being part of the community the CHW is on the look out for such patients amongst his 30 families and anybody with the relevant symptoms is motivated and referred to the health facilities for investigation by sputum tests and chest X-ray, thus helping and increasing the case identification activities of the BHU.

Once the patient has been diagnosed and registered, he is given the necessary health education and treatment, and his CHW is immediately notified. For patients who are liable to default or discontinue treatment, repeated and persistent health counselling and motivation is extremely important. This requires time and obviously becomes difficult for a single BHU staff member, who has other responsibilities as well.

Because they are close to the patient and have just a few cases to handle, the CHWs can afford the time and regular attention needed to motivate such patients. In this respect they have been very effective, ensuring regular treatment and follow up examination at appropriate intervals. From the point of view of the BHU, tracing defaulters through the CHWs has become very easy, as every record system includes the name of the CHW (see Use and Advantages of PHC Activities Chart, 6.4.2.). The CHW keeps a close watch on the contacts of sputum positive cases, and immediately refers those with symptoms to the BHU for the necessary investigations.

With the above measures our case detection has reached optimum levels, and we have been able to improve patient compliance, reducing the number of defaulters to practically nil.

7.7.2. Malaria Control/Sanitation Programme

Febrile cases are referred on suspicion by the MO to the malaria supervisor for blood smears and a presumptive dose of chloroquine. Having done this the malaria supervisor instructs the patient to attend the BHU on a date by which the results of the smear test are likely to have been received from the laboratory.

The positive cases who turn up as requested at the BHU are given chloroquine and primaquine tablets for radical treatment. The way these are to be taken is explained to the patient. The positive cases who do not turn up at the BHU to receive their results on the date requested are traced by the malaria supervisor (using the name of the CHW in the recording system) and appropriate action is taken. The patients are also instructed to return to the health facility seven days after the start of the radical treatment for a follow up blood smear examination. Patients who do not appear for the follow up are again traced.

Patients showing negative results in the first follow up are deemed to have been cured, but they are instructed to report to the health facility immediately in case of a febrile illness. On the other hand, if the first follow up shows malaria parasites, the patient is again given the drugs for radical treatment, but the administration of drugs has to be supervised and he is also directed to attend the BHU a week after the start of this treatment for a second follow up.

In the majority of cases the second follow up is negative, showing that the radical treatment was not properly taken the first time. If, however, the second follow up is positive, the patient has to be referred for a drug sensitivity study. Check surveys are done in which blood smears are taken from all the family members of the case suffering from falciparum malaria and a number of houses surrounding his own.

Insecticide sprays are used twice a year at the proper times. Larvicidal activities include filling up ditches, etc. where water stagnates and provides a breeding place for mosquitoes. Where that is not possible old motor oil is used, or other substances that prevent breeding.

It has to be admitted that the sanitation aspect of our programme is not as well developed as others. It is limited to the construction of latrines, the making of garbage disposal pits in individual houses and ensuring that proper sanitary protection is observed by shops and vendors selling edible items.

(i) *Difficulties in implementation:*

1. Convincing people, especially those who are symptomatic and reside in areas where falciparum infection is suspected, to go to the BHU for blood tests;
2. Tracing people who fail to attend the BHU to be told about the results of their blood examination and, if positive, to be given drugs for radical treatment;
3. Persuading people to attend the BHU for follow up examinations, especially those who become asymptomatic after radical treatment;
4. Gaining access to houses for check surveys;
5. Supervising radical treatment when follow up examinations are positive. It was difficult not only for the sick patient to travel every day to the BHU for the supervised intake of his drugs, but also difficult for staff because of the high endemicity of malaria and thus the heavy case load;
6. The refugees live in mud houses and new construction is an ongoing process, which leaves large ditches where water accumulates in the rainy season and provides a perfect breeding place the mosquitoes;
7. The majority of Afghans in the camps are from a low socio-economic background and are used to answering calls of nature out in the open, thus the use and maintenance of latrines was a new concept for them;
8. In the circumstances, control over the sale of edible items and disposal of garbage was minimal.

(ii) *Role of CHWs in Malaria Control/Sanitation:*

Malaria is one of the most prevalent health problems amongst the refugees and is therefore a priority area in the health programme. CHWs are taught about causes and control, and can therefore keep their 30 families well informed about the disease, stressing the need for early detection and therefore blood smear examinations. Since the record systems give the name of the CHW for any patient, people who do not attend the BHU can be traced through the CHWs.

The help of CHWs was particularly evident in September and October 1987, when falciparum malaria had a much higher prevalence compared to other years. People covered by a CHW posed no problem, but patients from those pockets where there was no CHW were most problematic as it took a day or two to trace them. Individual harm to the patient (as this malignant malaria can kill if treatment is not started quickly) and the loss of time with so many cases to treat was heavily felt by the health sector.

CHWs provide a way to ensure proper administration of radical treatment. This is especially applicable in the peak malaria season, in cases where the first follow up smear is positive, and where improper intake of radical treatment is a possibility and has to be excluded before sensitivity studies are conducted. The CHWs have been instrumental in (a) motivating people for follow up examinations when informed, by the BHU through the CHSs, of positive cases among their 30 families; and (b) filling up ditches and carrying out other larvicidal activities, and motivating and utilising the manpower of their 30 families on a self help basis.

Their persistent education on the advantages and use of latrines and proper garbage disposal has had an impact which is evident in the demand from the refugees for the provision of cement slabs to cover the pit latrines, which they have voluntarily dug themselves.

All these efforts have helped to achieve a reasonable control over malaria, and during the epidemic of falciparum malaria in late 1987, which caused high mortality in other areas, only one death occurred in areas covered by the CHWs. The changing attitudes of refugees towards sanitary practices are also significant.

7.7.3. Immunisation Programme

The target groups for immunisation in the Afghan Refugee Health Programme are:

1. Children under five, who are immunised against six infectious diseases as follows:

   (i) *Tuberculosis*: BCG vaccine, given in a single dose at birth or as early as possible after birth;

   (ii) *Polio*: oral vaccines, given at birth as birth polio, then in three doses, starting from a minimum age of 1.5 months, with a minimum interval of a month each dose;

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The schedule for immunisation of children under five should read as follows:

(iii) Diphtheria: DPT vaccine, given in three doses, the first at a minimum age of 1.5 months and the other two at monthly intervals like OPV; <u>or</u> DT vaccine, given in two doses with a minimum interval of a month between them, to children who have attained two years of age and were not immunised with DPT earlier.

(iv) Pertussis: DPT vaccine, as in (iii) above.

(v) Tetanus: DPT or DT vaccine, as in (iii) above.

... conditions, the infectious nature of these diseases, the morbidity and mortality that they can cause and the ease with which they can be controlled through immunisation, this activity therefore receives top priority in the health programme.

The target set for the health sector is to provide complete immunisation coverage to over 80% of the target groups.

The difficult process of convincing the largely illiterate and completely curative orientated Afghan society of the benefits of immunisation is complicated by the lack of immediate and apparent results, slight pain and febrile responses and very occasional allergic reactions.

Complicating the whole issue still further is the fact that in order to achieve complete immunological protection some vaccines need to be given in two or three doses, with a minimum interval of a month between each dose. Combined with the factors mentioned above, this causes a very high drop out rate between the first and the third doses.

Another reason for the high drop out rate is the difficulty of tracing large numbers of children and women who are due for their second or third doses and have not turned up at the health centre on the arranged date.

It is extremely important for the vaccinator to know whether it is the first dose that he is giving to an under five or the second or third. For this purpose cards showing the immunisation status of the target group in the household or family are filled up and handed over to the head of the family after immunisation. These cards have to be produced at the health centre when attending for subsequent doses, or at the house if the subsequent doses are given during outreach. Verbal information, even if available, is never reliable.

Immunological blood studies are costly and complicated and mass surveys to assess overall immunisation coverage are not possible, so these cards are also of vital importance to the health sector for the purposes of evaluation.

However, despite the fact that the importance of the cards is explained to the family and the need stressed to keep them safe, experience has shown that they are liable to be lost, resulting in various difficulties for the health sector.

Chapter - 3

AFGHAN REFUGEE HEALTH PROGRAMME

In 1979, just one year after the Alma Ata declaration, large numbers of homeless Afghans arrived at the border with Pakistan. The number of officially registered refugees is currently estimated at around 3.3 million, forming the largest single concentration of refugees anywhere in the world.

The Afghan refugee health programme has evolved rapidly over 6-7 years and with the addition of the community based element it has developed from scratch to a comprehensive PHC programme providing prevention, promotion, rehabilitation and basic curative services.

The programme's brief history comprises three distinct stages;

PHASE 1

In the initial emergency phase the programme concentrated on: determining requirements; curative care; fulfilling nutritional requirements in order to achieve a reasonable state of health among the refugees.

PHASE 2

During this phase the following was done:

a) The PHC infrastructure was established, health facilities called Basic Health Units (BHUs) were set up, one per 15000 population, and staffed with the following categories:

   (i) Medical Officer;

   (ii) Lady Health Visitor;

   (iii) Malaria Supervisor/Sanitarian;

   (iv) Dispenser;

   (v) Vaccinator;

   (vi) Midwife;

b) Preventive health endeavours were introduced. The provision of health care did improve in this phase, but because two of the most important aspects of PHC, that is health education and community participation, were not developed to their full potential in the existing health set up, a lot was also left to be desired. Despite all efforts it was not possible to go beyond a certain point, for it was not possible for a few staff categories of a BHU to reach every doorstep without the help of the community. SCF(UK) was grappling with this problem at its pilot project at Badaber refugee village near Peshawar, capital of the North West Frontier Province (NWFP) of Pakistan.

Role of CHWs in Immunisation:

1) *Motivation*

During their training CHWs are given a clear understanding of the protection that vaccines give to a child or CBA and the consequences if either falls victim to one of the six diseases. The CHW is therefore able to motivate his 30 families by explaining to them the advantages of immunisation and the disadvantages if target groups are unprotected. It has been felt that, being part of the community, motivation by the CHW is much more effective than that of the health staff. Moreover, it is not possible for the health staff to accurately identify every household which is not convinced about immunisation, and then find the time to motivate individuals and families. This aspect can and has been adequately and effectively dealt with by the CHWs.

Experience in our programme shows that very little motivation, if any, is necessary for families which have CHWs. On the contrary, we have received heated demands for immunisation from groups of families which for some reason have not been immunised.

2) *Reducing Drop Out Rates*

One of the main problems, even among well motivated circles, was a very high drop out (or default) rate for those vaccines which required two or three doses at monthly intervals for complete protection. This not only wasted time, effort and costly vaccines, but also failed to provide protection to the target groups. This problem has been overcome almost entirely since the names of the CHWs have been included in the recording and reporting systems and an appropriate follow up system designed.

The follow up system works like this: a small booklet is kept for each month, with each page used for a different working day. When a child or CBA receives the first dose they are given a card number. The name of the child and the name of the CHW are recorded in the follow up booklet on the page for the date on which the next dose is due.

Take, for example, a child named Asif, age three months, CHW's name Malook, who received his first dose of OPV and DPT vaccines on 3rd January 1988 and was given card no. 20. He would be due for a second dose on 3rd February 1988, and this would be entered in the follow up booklet for February 1988, on the page for the third day of the month, as follows:

Date 3.2.88

Asif, card No. 20, CHW Malook

All under fives and CBAs whose subsequent doses are due on 3.2.88 are recorded on this page in the same way. By this system the vaccinator knows the card number, name and CHW of every child or CBA who requires a second or third dose on a given date. With this

information, the vaccinator prepares every weekend a list of people who require a follow up dose, for each day of the coming week. These lists are handed to the CHSs, who inform the relevant CHWs. The CHWs then motivate the families or individuals to attend the health facility for immunisation on the required date. In this way most of the children and CBAs attend the BHU for immunisation on the proper date. Those who do not are easily traced by the vaccinator and immunised during outreach visits. By this method, defaulters have been reduced to 2-3%, which is a big improvement on the very high percentage (almost 35-40%) before the integration of the community services.

7.7.4. MCH Services and Oral Rehydration Therapy (ORT)

It is needless to comment on the importance of the MCH services as the main risk groups the under fives and pregnant and lactating women. In our health programme, weekly antenatal & under fives clinics are held. Both clinics are run by the LHV who is assisted by a midwife. In problem cases the advice of the MO is sought.

(i) *Under Fives Clinics:*

It is policy to monitor the growth of all children under five on the basis of weight for age. Road to Health Charts are used to record the child's progress in terms of weight gain or loss with increasing age.

Over the years it has been ascertained through surveys that the prevalence of malnutrition among the refugees is around 2-3%. In the majority of cases, malnutrition is the result of ignorance or misunderstanding about basic health issues, or the secondary result of disease (mainly diarrhoea, but sometimes also respiratory infections).

Most under fives are affected by malnutrition at 4-5 months and 9-12 months, ages at which improper weaning practices and diarrhoeal disease play a major role.

Ignorance of basic facts about health is not only a major cause of mal nutrition but also a complicating factor as far as the staff of health facilities are concerned. Lack of health education is a broad term, and to treat malnutrition the health staff have to determine the precise cause for each child, and deal with it accordingly. To do this effectively, the staff not only have to compile a good dietetic history of the child, they also have to work closely with the family, observing their nutritional practices and noting any departure from healthy ways. All this requires not just efficiency, but quite a lot of time and effort.

(ii) *Antenatal Clinics:*

As policy, all pregnant women are registered at antenatal clinics as early as possible, using antenatal registration cards filled in by the LHVs. Depending on the duration of pregnancy, the females are followed up at monthly, fortnightly and weekly intervals and the

information is recorded on the antenatal cards. Deliveries should ideally be conducted by the LHV and postnatal follow-up carried out daily for ten days following the delivery.

(iii) *Difficulties:*

The strict religious and sociocultural patterns (purdah) of the Afghan community has made this most important area of the health programme the most difficult one to manage. Moreover, a BHU has only two staff members, the LHV & midwife, to look after the MCH services, and each BHU caters for a population of some 15,000 people, with approximately 2,700 under fives (18% of the total population) and about 1,200 pregnant mothers (8%). The LHV is responsible for all the activities listed above, including registration and follow up of all under fives and pregnant women, conducting deliveries and postnatal follow-ups. She also has to help the MO to conduct female out patient sessions (since Afghan women would never speak about their obstetric/gynaecological complaints to a male MO, and allowing a MO to physically examine them is a another story).

It should also be borne in mind that, with parental or family ignorance being the main cause of malnutrition, all that is needed is education in correct practices, but to the illiterate and curatively-orientated Afghan mothers this can seem like a complete waste of time. For all these reasons, follow-up for growth monitoring and antenatal checkups, especially with healthy children and pregnant mothers, has been a major problem and an area which requires a lot of time and effort.

With regard to deliveries, the extent to which services can be provided is limited by the times at which deliveries occur. Staff duty hours are 6-8 hours, starting from 8.00 am. Experience has shown that most deliveries occur in off duty hours, but even if they took place during duty hours, conducting one delivery would be at the cost of a lot of other work. Similarly, if postnatal follow up checks were made on all new mothers for 10 days after birth, the distances and time involved in reaching different patients would mean that the LHV would not be able to attend to the rest of her duties. The above reasons have, unfortunately, made the MCH services the most difficult area of the health programme.

With the BHUs understaffed for MCH services and the categories for it extremely overbooked, one tends to question the policies. Having realised this for some time, the health sector in Hazara division decided to concentrate only on cases of maximum risk. In doing so it amended policy and developed its own recording and reporting systems so as to provide the best possible services in the existing circumstances.

According to these amended policies, registration has been confined to children under one (since this is the age group most affected), and children aged 1-5 who are underweight or have one or more major risk factors. Postnatal follow-ups in routine cases have been reduced

to two, on the first and sixth days after birth, with more frequent follow-ups or preferably referral to a hospital with specialist facilities in cases where there are any complications.

These were put down on paper in their final shape and circulated to staff in January 1988. Later, in February 1988, these recording and reporting systems were approved for the whole of NWFP by the PDH with slight modification considering other areas. Visiting delegates from the Afghan Refugee Health Programmes in Baluchistan and Punjab provinces also took note of these systems for implementation in their areas.

It may be noted that the above policies were in practice at our clinics from September 1987, and we have been noting deficiencies in the initial forms. After field testing the card and correcting faults over a three to four month period, we were able to give a final shape to the policies, the register and monthly report for antenatal, natal and postnatal activities, the growth chart register and the monthly growth monitoring report.

It must be admitted that despite the amended policies, MCH services remain a difficult area, for the variety of reasons given above. Very little could be done about deliveries - one of the most important aspects of these services - and the majority continue to be conducted by the refugee women themselves rather than the LHV or other trained health personnel.

The only progress that the health sector has made in this area is that, from the available records in the clinics in relation to CHWs, the health staff are able to identify:

a) low numbers of antenatal or under one registrations from a particular area;

b) the expected dates of deliveries of cases registered in the antenatal clinics.

With this information, the staff are able to increase their motivational activity in areas which produce lower than expected numbers of antenatal cases; this has helped improve the antenatal coverage of the clinics to over 90%.

(iv) *Role of CHWs in MCH:*

(a) *Growth Monitoring:*

Having been taught about malnutrition and provided with a measuring band to take the mid upper arm circumference, the CHWs help the BHU in the identification of malnourished cases. They also keep motivating the community to register at the under fives clinic. CHWs are immediately notified if a case of malnutrition is registered from their thirty families, either through the referral system or through the CHSs. From that point onwards the CHWs play a very important role in helping the BHU identify the cause of malnutrition and in motivating

the family to seek regular follow-ups. Both these areas need persistent effort and in most cases a lot of time, which for a single overworked LHV is almost impossible to afford.

Having said all this, the role of the male CHW, though very helpful, cannot be utilised to the full throughout the Afghan community. The daily life of infants and under fives revolves around the women, and the movement of men in the female circles, no matter how closely related they are, is considerably restricted.

The CHWs also continue to teach their 30 families about the concepts of healthy nutrition, and by correcting any departures from health practice in this area they help to prevent malnutrition. However, sex again plays a restricting role, as they cannot talk to the women about important matters such as breast feeding and proper weaning practices. Their messages have to reach the men, which is not the best way.

(b) *Antenatal, Obstetric and Postnatal Services:*

Because of the very strong religious and sociocultural constraints, the role of the male CHWs in this respect is practically nil. In effect it is limited to the identification of registered cases by the LHV from the records, which is of importance in notifying the expected dates of deliveries and motivating for regular antenatal follow-ups by the LHV. Nothing in this area can be channeled through the CHWs. A strong need therefore exists for some sort of female community service - ideally one trained traditional birth attendant per thirty families, on the same basis as the male CHWs - and for this service to be linked, monitored and integrated into the existing health services by a staff category called the community dai (midwife), like the CHS in the male programme.

(v) *Oral Rehydration Therapy:*

This is an area which we have been able to improve to a great extent with the help of the CHWs.

As one of the commonest disorders, diarrhoea has also become the disorder for which the advice of the CHW is most often sought. For patients who seek advice on diarrhoea from the BHU, the first line of treatment is oral rehydration salts (ORS, usually enough for one litre of water).

The way ORS is to be mixed with water is clearly explained to the patients by the staff of the BHU, but almost always the patients are directed to seek the help of the CHWs in preparing the solution. The CHWs teach this by making the solution in front of the patient or a family member, and then asking them to prepare it themselves. This ensures the proper method of preparation in long term.

However, if asked for advice directly by a patient, or when talking about the treatment of diarrhoea during daily home visits, he recommends home made solution in which table salt and ordinary sugar are mixed with water in appropriate quantities, rather than ORS in a packet. Because the concentration of sugar and salt has to be within a particular range, special attention has to be paid to measurement, since this is where most errors, affecting the absorption of the solution, occur.

The CHWs have a standard 5ml teaspoon and a cup or glass which holds a known amount of water. The solution is prepared by dissolving 8 level teaspoons of sugar and one level teaspoon of salt in a litre of water. The CHW first identifies a vessel in the house and marks a point on it to measure a known quantity of water. For the sugar and salt they find a standard teaspoon and demonstrate how to take a level teaspoon. The CHW first makes the solution once himself and then asks a family member to do it. This ensures appropriate quantities of salt, sugar and water in the rehydration solution and also the future preparation of the solution without the supervision of the CHW.

In peak diarrhoea seasons we have conducted planned mass ORS campaigns through the CHWs. During these, the CHW goes to at least three houses a day to demonstrate and teach the preparation of ORS and its use. Thus a CHW would complete the task for his 30 families within 10 days. This was done in the early days after the integration of the community services, but as time went on we found that such campaigns were unnecessary, since the preparation and use of ORS was a routine activity in the CHW's health education sessions; in areas covered by CHWs a large majority were well educated in this respect. The CHWs have instructions that if diarrhoea does not correct itself within 2-3 days after the start of rehydration therapy the case should be referred to the BHU for the advice of the MO.

7.7.5. Basic Curative Services

The basic curative services comprise of the dispensing of drugs to diagnosed patients and minor surgical procedures like abcess drainage, minor wound stitching, etc.

For some time, the main difficulty in outpatient care was the very high number of patients - on average around 150 cases a day to be seen in 5-6 hours of official time. A fairly large proportion of these patients was made up of people requiring very basic first aid. Because the MO was supposed to examine and diagnose all patients, and screening was not regarded as a reliable method, it was difficult for the MO to identify the genuine patients and find the time to examine and diagnose them.

Another difficulty was the use of medicines. Despite the fact that clear instructions had been given by the staff of the health facility, illiteracy and ignorance among the Afghan community would lead to deviations from the correct dosage, frequency of intake and duration of treatment, resulting in a significant waste of costly drugs, without producing any results. For example,

tuberculosis patients would stop taking drugs after two or three months of treatment, when the symptoms subsided, while antibiotics would be used in inadequate doses or for inadequate periods, or both. The preparation and use of ORS has already been discussed.

Another aspect that needs to be mentioned under the heading of curative services is illegal medical practice. The mass illiteracy and the heatlh conscious nature of the Afghan community has lead to flourishing illegal medical practices and quackery in the refugee villages. This has created a number of very serious problems for the health sector, including for example cases of paralysed lower limbs caused by injury to the sciatic nerve, the result of injecting drugs incorrectly into the buttocks of children, as well as anaphylactic shock due to the allergic reactions.

Role of CHWs in Basic Curative Services:

With basic first aid available to the community at home and round the clock, most first aid cases turn to the CHWs, which is much more convenient. The continuous emphasis by the CHWs on the unnecessary use of drugs has also helped to reduce the unnecessary case load on the health facility. The developed referral systems have helped. For example, in a case referred to the BHU by the CHW it is understood that the patient has already received basic first aid but the complaint persists. This would automatically mean that the patient requires a thorough medical check up, and the MO thus makes sure that all such cases get it.

Referral from the BHU to the CHW is carried out by means of a referral slip, giving instructions about the dosage, duration, etc. of the drugs prescribed and given to the patient. Any help the patient needs in this respect can easily be sought and obtained from the CHW by use of the refer ral slip. Moreover, the CHWs are informed about the number and names of tuberculosis patients and those with other serious conditions in their 30 families, and they continue to motivate and advise the patients to stick to the regime advised by the BHU.

The CHWs have also been instrumental in highlighting to the community the serious consequences that can arise from illegal medical practice by unqualified people, thus discouraging the community from using such services.

Chapter - 8

ADVANTAGES OF THE PROGRAMME

8.1. The ongoing process of health education continues to act positively on the attitudes of the community towards health.

8.2. Smaller, easily quantifiable and identifiable groups make planning and implementation of preventive health programmes very easy.

8.3. Basic health services are available round-the-clock on the community's doorstep.

8.4. The general information provided at the end of each month by the CHWs is a good source of epidemiological data; this is important medical information which, besides going into the BHU records, is also used to plan its activities and priorities for the next month.

8.5. Unnecessary burdens on the health facility are reduced, because most patients with minor complaints now receive first line treatment from the CHWs; this significant reduction in unnecessary work has helped improve the quality of services provided by all staff categories to genuine patients.

8.6. The community services are of tremendous help to the BHU in tracing defaulters and motivating for compliance.

8.7. Guidance to the community on how to use different drugs ensures proper and effective utilisation.

8.8. Guidance to the community and reports to the BHU on different aspects of environmental sanitation and water supply.

Chapter - 9

POSSIBLE IMPLEMENTATION IN SETTLED AREAS AND OTHER COMMUNITIES

The success of the Hazara PHC system in providing better health services and improving access to a most difficult and underdeveloped community with an unstable administrative and developmental structure, through a temporary project with minimal resources, shows that it could be an asset for health programmes in settled communities, where planning, timely action and the collaborative effort so necessary for the desired impact of PHC would all depend on a single policy decision by the relevant authorities. The teaching curriculum and method could be adapted to suit the needs of the par ticular community.

Having said this, it is felt that all communities, particularly those of underdeveloped nations, must decide on their priorities as far as the health of their nation is concerned.

While the balance between the preventive and curative side is important. In Pakistan it should definitely tilt more towards prevention and basic health needs. It is neglect of this area which results in tremendous morbidity and mortality, whilst improvement can bring about dramatic changes in these figures.

PRIMARY HEALTH CARE WITH AFGHAN REFUGEES IN PAKISTAN

Some lessons from experience



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Publication Sponsored by: SAVE THE CHILDREN FUND (UK) November [illegible]

There they developed a system which included mechanisms for community participation and health education. This consisted of:

(i) Volunteers in the form of CHWs, each providing health education and basic curative care for an extended family group of approximately 30 families;

(ii) A link between the BHU and the community in the form of a CHS trained by SCF but subsequently employed by the Government of Pakistan.

The Commissioner for Afghan Refugees (CAR) in NWFP invited SCF to plan the PHC programme and to integrate it into the existing health infrastructure of all Govt/UNHCR basic health units for the refugees.

Responding to the invitation, SCF started planning a PHC programme for all the Afghan refugee villages in NWFP.

Through the active participation of the refugees, the aim of the programme was to train one CHS for every 7,500 refugees, who would be employed in the BHU and would be responsible for the training and supervision of the CHWs.

All the above community services were to be integrated into and would provide an extension of the services provided by the BHU, with the CHS acting as a link between the community and the health facility.

PHASE 3

With the integration of the community services, consisting of CHSs and volunteer CHWs, the health programme entered into its third phase.

Chapter - 4

ISSUES SURROUNDING A PHC PROGRAMME FOR AFGHAN REFUGEES

Before the implementation of a PHC programme in any community a number of factors have to be borne in mind, including the characteristics of the community and the existing health service structure. These are briefly discussed below:

4.1. Socio-Economic and Cultural Traditions of Afghan Refugees

A refugee society is reliant on external aid for survival; it is unstable and displaced. Afghan refugees, however, are deeply religious and observe Islamic principles and beliefs very strictly, including purdah.

One might expect an Afghan refugee society to be homogeneous and without internal frictions, as all refugees are struggling for the same cause. However this is not so, and the effects of historical rivalries remain, dividing the society into many tribes or groups with allegiances to different political parties.

Many tribal and sub-tribal groupings exist in a single refugee village. These groupings, along with purdah and internal frictions, greatly restrict movement and communication among the refugees themselves. Besides this, a traditional code of honour and method of decision making make it difficult to carry out any activity unless they have first been convinced that it does not go against their traditions or religion.

4.2. Health Status

The main health problems affecting the refugee community are tuberculosis, malaria, communicable diseases like measles, pertussis, eye and skin infections, and seasonal conditions like upper respiratory infection with high incidence in the winter months, and peaks of diarrhoea in the summer.

Thus the main health problems of the refugees, which cause high morbidity and mortality, are essentially preventable.

4.3. Existing Health Services (see Chart A next page)

Health services are provided to the refugees from the health facility in each refugee village, the BHU, each one serving a population of about 15,000. Each BHU is staffed by:

i) Medical Officer;

ii) Lady Health Visitor;

iii) Malaria Supervisor/Sanitarian;

iv) Dispenser;

v) Vaccinator;

vi) Midwife.

CHART A: ORGANOGRAM OF HEALTH SERVICES FOR AFGHAN REFUGEES

	UNHCR		GOVERNMENT OF PAKISTAN
1. FEDERAL/MINISTRY LEVEL			
a)	Headquarters Geneva	<---->	States & Frontiers Ministry (SAFRON)
b)	Headquarters Pakistan (Islamabad)	<---->	Chief Commissionerate for Afghan Refugees (CCAR) Islamabad
	Senior Health Coordinator	<---->	Director Medical Services
2. PROVINCIAL LEVEL			
a)	Sub offices (Peshawar/Quetta)	<---->	Commissionerate for Afghan Refugees (CAR)
	Healh Coordinator	<---->	Project Director Health (PDH)
			* Liaises with Voluntary Agencies with Province wide brief, such as: TB control, PHC, etc
	Voluntary Agencies operating on province level		
3. DISTRICT LEVEL			
			Field Supervisory Medical officer (FSMO)
			* Monitors Voluntary Agencies responsible for provision of health services in refugee villages.
4. LOCAL LEVEL			
	Voluntary Agencies BHUs	<---->	Basic Health Unit (BHU)
			Medical Officer Medical staff and paramedical staff

Besides preventive services like immunisation, Mother and Child Health (MCH) services and disease control, the BHU provides basic curative services through daily out-patient clinics. Cases requiring hospitalisation or expert opinion and management are referred to the nearest Government hospital where they are treated free of cost.

The Afghan Refugee Health Programme is a collaborative effort of the Government of Pakistan, UNHCR and international voluntary organisations. The Government of Pakistan is responsible for coordination and the allocation of funds provided by UNHCR. These funds are used by the Government of Pakistan to set up the BHUs, to pay the salaries of the health staff, to purchase medicines and equipment, to meet the recurring costs of vehicles, disease control and health promotion programmes, and also to assist Government health facilities which provide referral services for the refugees. The Director of Medical Services at the Chief Commissionerate for Afghan Refugees (CCAR),

Islamabad (part of the States and Frontiers Organisation) coordinates the implementation of the programme at national level. He is assisted in this at provincial level by the Project Directors of Health. Field Supervisory Medical Officers (FSMOs), under the control of the Project Director, supervise the health sector at district level.

The Project Director and his FSMOs also coordinate and monitor the health services provided by the voluntary organisations, who have to work within the policies laid down by the Government of Pakistan/UNHCR.

As well as financial support, UNHCR assists the Government by making available advisory services, for which there is a Senior Health Coordinator at federal level and Programme Coordinators at provincial level.

4.4. Community Attitudes Towards Health

The Afghan community is very concerned about its health. For instance, a man will travel miles for what may turn out to be a minor condition. But unfortunately their perception of health is totally curative, with no understanding of preventive concepts. One of the reasons is that a large majority of these people are illiterate, and the preventive aspects of their medical services in Afghanistan were either poorly developed or never existed.

4.5. Attitudes and Orientation of Health Staff

The majority of staff working in the Afghan Refugee Health Programme are Pakistani; a very small percentage is Afghan.

(i) *Medical staff:*

The medical schooling of the Medical Officers in both countries has minimal preventive orientation, with no emphasis or practical training in preventive or community medicine. The products of such training start work in the Afghan Refugee Health Programme with a totally curative approach and with no idea of how to organise, manage or carry out preventive or promotive activities. As well as deficiencies in medical training in preventive fields, the Medical Officers have virtually no managerial or administrative skills with which to make the best use of every staff member.

(ii) *Other BHU staff:*

Lady Health Visitors (LHVs), Vaccinators, Malaria Supervisors/ Sanitarians: Although these categories have had training in their respective fields, when they join the service their practical abilities and knowledge are very poor, and their attitudes are much more inclined towards a passive approach. Staff tend to prefer to remain in the BHU and do not undertake outreach activities on their own initiative.

Adding to these difficulties is the temporary nature of the job. The majority of Medical Officers are fresh graduates taking temporary employment in the ARO, to bridge the gap between unemployment and finding a secure job with the Government. This is also true for

other categories, though not to the same extent. Thus with only short term employment in mind the attitude of the staff is rather casual and difficult to change.

In-service training, seminars, workshops etc. and continuous emphasis through monitoring and supervising authorities has helped to modify attitudes and to orientate longer serving staff members. While the in-service training in preventive care is receiving top priority in the programme, guidance in management and leadership has unfortunately been ignored in most areas.

4.6. Administrative Support

Strong administrative support is needed if the collaborative effort so necessary for a successful PHC Programme is to be achieved.

Chapter - 5

TRAINING AND THE IMPLEMENTATION OF THE PHC PROGRAMME

The integration of community based PHC services into the existing health service and its implementation can be seen to have passed through two distinct phases. They are: Phase 1 - motivation, selection and training, Phase 2 - managerial.

5.1. Phase 1: Motivation, Selection and Training

This can be seen as a preparatory phase. In the Afghan Refugee Health Programme this is almost entirely dealt with by SCF(UK). A strong foundation is laid for a solid structure to be built afterwards; as no strong structure can be built on a weak foundation the importance of this phase cannot be over-emphasised.

The role of the Government health sector of the ARO is minimal in this phase. It is only involved in order to be accurately informed of all activities and to extend help and support wherever possible.

The phase includes:

i. Introduction of the concept of the programme and community motivation;

ii. Formation of Health Committee;

iii. Selection and training of CHSs;

iv. Selection and training of CHWs;

v. Health staff motivation and integration of the system with the existing health services.
(Further details of the various phases are given below)

5.1.1. Introduction of the Concept of PHC and Community Motivation

Prior to commencing the work of community motivation, introductory visits are made by expatriate PHC advisors and other staff of SCF(UK) to District and field level staff of the health services, as well as to the staff of the General Administration in the ARO.

In order to disseminate knowledge to all relevant sectors, and to the community in particular, and in order to make the community understand and appreciate the importance of participation in its own health care, SCF has been using the services of mobile motivation teams. These are each made up of five Afghan refugees who have been trained in specific procedures, utilising the traditional channels of communication within the refugee society.

Using methods acceptable to the refugee communities and working in close cooperation with the BHU and the administrative personnel of the refugee villages, the mobile teams motivate the community through meetings, discussions and visits to family groups, exploring the programme in detail.

PRIMARY HEALTH CARE WITH AFGHAN REFUGEES IN PAKISTAN

Some lessons from experience

A working paper addressing a number of issues related to management and supervision of Primary Health Care programmes and integration with government services during the various stages of implementation

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Publication sponsored by: SAVE THE CHILDREN FUND (UK), November 1989

FOREWORD

In December 1979, following the Russian invasion of Afghanistan, the first refugees arrived in Pakistan. Today, 10 years later, there are over 3,000,000 Afghans in Pakistan, constituting the largest refugee population in the world.

The Government of Pakistan, through the Project Directorate of Health for Afghan Refugees, provides health services in the refugee villages through Basic Health Units. However, not all refugees can avail of these services. The traditions and culture of the Afghan people, and the strict observance of purdah, particularly restrict the women and children.

In 1983, Save the Children Fund (UK), introduced a Primary Health Care Programme in the Afghan Refugee Villages in North West Frontier Province. This programme trains refugees to become Community Health Workers representing their own extended family groups. In this way the health services are extended to reach all members of the family, and the community is involved in the improvement of its own health status. In 1984 the programme was introduced in Haripur District, Hazara Division.

Dr. Waqar Ajmal graduated from Khyber Medical College, Peshawar in Pakistan. He joined the Project Directorate of Health for Afghan Refugees in 1981 as a Medical Officer in a refugee village in Haripur. In 1982 he was promoted to Field Supervising Medical Officer, in charge of 19 Basic Health Units covering a population of 215, 427 refugees.

From the first introduction of the programme, Dr. Waqar took exceptional interest in the Primary Health Care Programme. He developed new systems for effective supervision and monitoring of the Community Health Worker's activities. he also designed reporting forms and charts for these systems. The ideas developed in Haripur have had a significant influence on the Primary Health Care Programme in the province.

In the areas where the Primary Health Care Programme has been implemented, there has been a noticeable improvement in the immunisation coverage of the under five population and women of child bearing age. Also the numbers of persons defaulting from tuberculosis and malaria treatment have substantially decreased. As the communities have seen the benefits of the male Community Health Workers, there have been requests for a female programme in many areas. In view of the Afghan culture and traditions, this is an indication of a considerable change in attitude due to increased awareness in health matters.

For the successful implementation of a Primary Health Care Programme, effective systems of supervision, monitoring and evaluation must be established. In the paper Dr. Waqar explains the methods devised in Haripur District and outlines his views on the potential relevance of these methods in other situations.

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LONDON
NOVEMBER 1989

LIST OF ABBREVIATIONS

ARO	-	*Afghan Refugee Organisation*
BHU	-	*Basic health Unit*
CAR	-	*Commissionerate for Afghan Refugees*
CBA	-	*(Woman of) Child Bearing Age*
CCAR	-	*Chief Commissionerate of Afghan Refugees*
CHS	-	*Community Health Supervisor*
CHW	-	*Community Health Worker*
FSMO	-	*Field Supervising Medical Officer*
IMR	-	*Infant Mortality Rate*
LHV	-	*Lady Health Visitor*
MCH	-	*Mother and Child Health*
MO	-	*Medical Officer*
NWFP	-	*North West Frontier Province*
ORS	-	*Oral Rehydration Salt*
ORT	-	*Oral Rehydration Therapy*
PDH	-	*Project Directorate of Health*
PHC	-	*Primary Health Care*
RVA	-	*Refugee Village Administrator*
SAFRON	-	*State and Frontier Ministry*
SCF (UK)	-	*Save the Children Fund (UK)*
TB	-	*Tuberculosis*
TT	-	*Tetanus Toxoid*
UN	-	*United Nations*
UNHCR	-	*United Nations High Commissioner for Refugees*
UNICEF	-	*United Nations Children's Fund*
WHO	-	*World Health Organisation*

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